TRANSCRIPT OF PROCEEDINGS

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2015/16 HAZELWOOD MINE FIRE INQUIRY

HEALTH IMPROVEMENT FORUMS

TRARALGON

TUESDAY, 29 SEPTEMBER 2015

THE HONOURABLE BERNARD TEAGUE AO - Chairman

MRS ANITA ROPER - Board Member

PROFESSOR JOHN CATFORD - Board Member

MR PETER ROZEN - Counsel Assisting

MS RUTH SHANN - Counsel Assisting

MS JUSTINE STANSEN - Solicitor

MS SHANN: This is the early detection and high risk screening session. The panellists are very learned and we have had an extremely productive and interesting session, so we are now here to share the results with the group and in particular for the participants to report back to the board.

There is a Powerpoint presentation and the first slide is up. Before handing over to the Chair, Andrew Tonkin, who is going to take us through and throw to various participants on issues, perhaps if each person in turn could just introduce themselves and where they are from.

PROFESSOR CLARKE: David Clarke. I'm from Monash Health, psychiatrist.

PROFESSOR TONKIN: Andrew Tonkin, cardiologist by training, now at Monash University.

MS SCOTT: Heather Scott. I am a registered nurse and I'm currently working at Latrobe Community Health.

DR WRIGHT: Alistair Wright, general physician at Royal Latrobe.

DR STEINFORT: Daniel Steinfort, respiratory physician at Royal Melbourne Hospital.

MS SHANN: Royal Latrobe, a new beast I haven't heard of before. Andrew, I will throw over to you and I will sit down. I will jump up if I see someone with a particular question, but you are all looking very self-sufficient. If you let us know when to change the slides, then we will move forward in that way.

PROFESSOR TONKIN: Thanks very much. First of all, I would like to thank everyone who is on the group with me and also thank the people who were observing because a number

of them made very, very pertinent comments and drew us into discussions that we may not have otherwise got into and we are very grateful for that.

In terms of what I would like to make comments on, I would like to talk a little bit about the terminology of early detection and high risk screening. Specific conditions I will make some comments on, but I think a lot of this is not about specific conditions, it's about what we are going to do in terms of early detection, high risk screening for chronic and other acute conditions, particularly associated with the coal mine fire, but also in the context of the health of the Latrobe Valley.

I will make some comments about risk assessment, what is available, screening options and even though there's only relatively few slides at the end about barriers, enablers and priorities, I think that's where most of the discussion should take place. If I could have the next slide.

The first comment I make is that I think in terms of thinking of high risk screening it is important to consider the burden of disease. In that context I think it's relevant to think about the high burden of disease associated with many non-communicable diseases that existed in the Latrobe Valley and to think about the way in which they might have been impacted by the coal mine fire and ongoing ramifications after that.

When we are doing high risk screening, as I said, there should be a high rate of disease that you are detecting. You need to easily be able to identify the risk factors and ideally those risk factors should account

for the high proportion of the disease outcomes. We want to have available effective interventions. If you can't intervene after you have detected, there is really little to be said for screening. That needs to be cost effective and therefore you need to take into account what are those interventions and what is the evidence that they will translate to improved outcomes in a valuable way, and also it's useful to know whether there are guidelines, processes and funding currently available, because a lot of what might be done could be done by just making the available resources, taking them to the community at this time as well as enhancement.

Next slide, please. Early detection should ideally not require more invasive investigation. If you take my area of interest, for example, cardiology, you don't want to be detecting coronary artery disease by doing an angiogram. That is not the way to go. The other comment I would make is that most people with, for example, atherosclerotic disease, which is a major health problem, already have it; they just don't know about it. So, if you do an angiogram you are going to find disease in most adults and so you don't want to go that way. In that condition, for example, specifically atherosclerosis, high risk screening and early detection is probably one and the same and so I won't talk further about early invasive detection.

You also need to consider whether there are appropriate algorithms after you detect a problem for the further management and whether those algorithms, those interventions which are put into place, how they impact on outcomes and also are there adverse consequences. To

amplify the adverse consequences, for example, one might use low dose CT scanning, computerised tomographic scanning. That involves a radiation risk and one needs to take that into account even though that risk is small. There is the anxiety that's associated with detection of a problem or the perceived detection of a problem, and also there's the possibility that what you might identify when you go through a screening process may translate into a relatively low number of true cases at the end of the further evaluation. So, all of those things are important.

Next slide. The conditions which we took into account were atherosclerotic cardiovascular disease and important risk factors for that such as elevated blood pressure, elevated cholesterol, diabetes associated with elevated blood glucose, and I will make some further comments about them, acute and chronic pulmonary disease, including lung cancer, and I will get our pulmonary expert to comment about that, depression, anxiety, poor social support. David Clarke beside me will make comment. One thing I want to emphasise is the importance of the conditions in the Latrobe Valley, the importance of disadvantage for all conditions and their outcomes.

In terms of risk assessment, I would like to make comment where relevant about available tools and guidelines for their use because they are going to be early wins if we can simply apply those and where there is good evidence for their value and cost effectiveness. We need to think about the ease of application within current and particularly the possibility of appropriately enhanced systems, and I will make comment about that in terms of

screening particularly.

We need to also think beyond just what we do in terms of health deliverers. We need to think about the people who are the important individuals in this, and that is the individuals in the community, and also particularly recognising vulnerable groups within the community. It is simply not good enough to stop at the level of screening because we are not following through in terms of communicating and helping those individuals to improve their health.

Not only that; unless we think about those vulnerable groups, we don't access the particularly high risk groups. I guess the exemplar would be Aboriginal and Torres Strait Islander people throughout Australia and there will be certain groups such as that here, as well as the Aboriginal people.

Next slide. For screening for cardiovascular disease, the National Vascular Disease Prevention Alliance includes, in no particular order, Diabetes Australia, Kidney Health Australia, the Heart Foundation and the National Stroke Foundation and it has come together and pooled expertise from not only medical, but also other professionals who are important in the development of what might be approaches to screening. They have come up and recommended nationally, and is now accepted, a tool for the assessment of risk of coronary heart disease and stroke and other coronary heart disease end points as well as infarction and stroke over the next five years.

That is based on data which is derived from population based studies where you might measure parameters of baseline, you follow the population forward,

you measure the outcomes such as myocardial infarction, heart attack and stroke, and then you do modelling to weight what are the significant independent risk factors. The next step is to validate that tool in a population which is similar to the one that you want to use, and ideally that would be in the Australian population.

That is a process that has been undertaken with a tool which has been developed in Framingham, just outside Boston in the United States, in Massachusetts. I'm involved with some others in developing a true Australian tool based on cohort data in Australia and you would be interested to know that that tool which would replace the Framingham equation will also strive to include a measure of socioeconomic disadvantage, of significant family history, of renal function and other things which may be important which are not included in the conventional tool. Our timeframe for the completion of that new tool is March of next year.

Currently, absolute risk assessment is recommended for those 45 and above who haven't been already identified as having high risk, for example, already had a diagnosis of coronary artery disease or have had a stroke or have chronic renal impairment, moderate chronic renal impairment, or who have diabetes. The tool depends on non-modifiable factors, age and sex, but also smoking, diabetes, cholesterol and blood pressure measurement.

Currently there is an MBS item for a single health check between the age of 45 to 49 with other items for assessment for Aboriginal and Torres Strait Islander people. That is embedded and a possibility in the health

system at this time but is not used in the way that it should.

Next slide. The United Kingdom has actually done further assessment of the possibility of vascular checks and they have now implemented these vascular checks on the basis of cost effectiveness analyses undertaken by NICE, the National Institute of Clinical Excellence. One has to be careful and apply caveats in applying data which is obtained in other health systems to the Australian health system. In other words, there are things that are unique to health systems, but the broad general principles are the same.

They recommended and have now implemented vascular checks in apparently healthy individuals funded every five years from the age of 40. They did that on the basis of the cost effectiveness modelling which showed that in terms of a disability adjusted life year avoided, the cost is only approximately $A6,000. That compares to what we actually might suggest might be the cost effectiveness bar, if you like, for implementing and recommending and subsidising new pharmacological agents of about $30,000.

So, this is something which is highly cost effective in the UK context and I think would be in Australia and I think it needs to be strongly considered in terms of what might be done to enhance assessment in the Latrobe Valley.

In terms of mental health, I will pass over to David.

PROFESSOR CLARKE: I will speak about the screening for mental health, but first just to add to what's been said. Andrew

has highlighted risk groups for vascular disease and one example being Aboriginal people. People with chronic mental illness are also at increased risk from diabetes and heart disease and people with chronic and severe mental illness have a mortality of dying earlier similar to Aboriginal communities. So they should also be targeted as a high risk population.

As for screening for mental illness, and I will focus on depression and anxiety because that's the common mental illness that goes unrecognised. In terms of disability it's up there with heart disease as one of the top two causes of disability in Australia. Screening can be done. There is no blood test that tests for it, but there are simple questions which encourage people to say that they are depressed and sad or not sleeping, et cetera. I won't go into the detail of how that's done, but there are accepted ways of doing it that can be incorporated in various clinical or questionnaire mechanisms.

Who would be the target group? There is no argument for screening everybody in the community for depression, but there is a strong argument for screening people in acute cardiovascular events, that is acute heart attack or acute stroke, and the argument is that depression in the context of a stroke or heart attack leads to a much poorer outcome, including mortality, and in the case of stroke severe morbidity, in other words lack of progress with rehabilitation. So in acute events it's recommended.

With chronic illness, so chronic heart disease, diabetes and arthritic conditions, et cetera, there's

argument for screening for depression because, one, it is common and, two, it impairs progress and there is data about that.

There are special groups that it is also worth considering. Youth is one of them. How would you do that? I will just leave that as a question. But youth depression and youth suicide is an issue. How do you uncover that so that you can recognise it and treat it is a challenge and Indigenous and Aboriginal people obviously is also a challenge. But the third special group is new mothers, so postnatal depression is not uncommon. It can be treated and has benefits for both the mother and the child. So there is acceptance in Australia that postnatal depression screening is worthwhile and has been funded by the Commonwealth government.

In terms of screening for the population, if we were to do in the Valley a community screening, then it would be very simple to include mental health in that and that will be one of our recommendations. Thanks.

PROFESSOR TONKIN: Thanks very much, David. Daniel, would you like to make comments about respiratory disease?

DR STEINFORT: We discussed chronic respiratory disease initially and looked at asthma and chronic pulmonary disease which might also be known as emphysema or COPD. Asthma we discussed really as a clinical diagnosis and certainly in the setting of airborne pollution particularly, that's not something that would require screening to detect. That would be a clinical diagnosis. So we didn't discuss that much more, given the context of screening.

COPD certainly can exist in a preclinical state,

so people can have the disease of emphysema without actually being aware of the diagnosis. There is perhaps a limited role for early diagnosis of COPD given that the ability to implement subsequent treatment and alter people's care is not clearcut, unless of course people actually have a clinical disease.

However, there is a large role - and this discussion came about particularly because of really valuable input from some of the non-panel attendees - there is a large role for health awareness and health promotion in terms of promoting early diagnosis of COPD and we discussed in that that there's probably a role for community based screening programs and early case detection which can be done quite simply with breathing tests or even just with a screening symptom questionnaire, and that's something that maybe you will discuss towards the end, Andrew, about one of the early things that could be implemented.

The other issue we discussed was CT screening for lung cancer. There is emerging data internationally suggesting that screening of appropriately selected high risk individuals may in fact improve detection rates of lung cancer and the subsequent survival rates and long-term mortality rates of people who undergo CT screening, but what's also clear is it is important to very accurately select the people who are at higher risk of lung cancer because there is the potential to in fact do more harm than good if you subject people who are at low risk of lung cancer to screening. So that's something that is still being examined internationally, but certainly there are pilot projects that are under way

within Australia which we could be involved in, but that's something more for the medium term to be considering.

The other issue that I think is an easy project would be to actually understand the risk profile of people within the Latrobe Valley region and that's something that perhaps we will be looking to move on in the next year or two.

The other issue that is probably particularly relevant to Latrobe Valley is the synergistic effect with respect to lung cancer risk of asbestos exposure on top of cigarette smoking. So that again is something that also means that certain parts of the Latrobe Valley population are at particularly high risk of lung cancer, making this a particularly pertinent point.

Lastly, throughout the discussion certainly with cardiovascular disease and particularly with respiratory health, far and away the most cost effective intervention is support for smoking cessation programs and anything that was to proceed out of this work would have to include that as an element. Thanks, Andrew.

PROFESSOR TONKIN: Thanks, Daniel. Can I have the next slide. In terms of the barriers, these are obviously multi-factorial, but at the individual subject level - and these slides were put together quite quickly and will miss out some of the things we discussed - but there is generally a lack of awareness about health and particularly the preventive nature of many of our health conditions, and that applies to chronic non-communicable diseases. If you take, for example, heart disease and stroke, about 80 per cent of that is in fact preventable, potentially preventable.

There is the question about disadvantage and particularly vulnerable subgroups. Those people who are most at risk in general access the services least and do not understand the possibilities, not through reasons of their own but for other reasons, and I think that that is a particular thing that we have to attend to. I think if we apply a whole of community approach even in the Latrobe Valley, I think we might just increase the disadvantage of those particularly vulnerable groups. So, I think what is done needs to be tailored to the relative disadvantage of the Latrobe Valley, but to the particular disadvantage also of vulnerable groups within the community.

There are the issues of access and transport. There is the question about the structures for implementing screening of the community, particularly outside of the usual medical framework. People in general would, I think, like to have screening done for conditions in the community environment. They would be more likely to attend, they would be more likely to come to such a facility if that was possible.

The funding for screening procedures is relatively lacking. We in Australia tend to have funding for health within the economic framework. The time course of negotiation of Medicare agreements between the Commonwealth and the state and territory jurisdictions particularly is hinged around hospitals and the care such as that. We don't have any way of, particularly at this time, valuing prevention. Everyone realises, though, and recognises that prevention is important and I think the opportunity is here in what is going to be done in the Latrobe Valley in the way in which we evaluate things

properly, you evaluate things properly, you can give learnings that are going to be important for the health of Australia more generally, particularly in the prevention area. A lot of this is about prevention.

The last thing is the ongoing management after screening. You cannot just screen and stop there. One has to think about what are the implications for what is found, for the health system but particularly for that individual, and they need to be supported to work their way through the health system, which is a very difficult one in many cases, and supported in terms of their ongoing prevention of disease and early treatment of disease and, associated with that, the barrier, the fragmentation of the care systems, and again the opportunity that I think arises in the Latrobe Valley for trying to break down some of that fragmentation.

The next slide is about enablers and in going through this I made one extremely important omission and I apologise for that. I meant to say upfront that usually prevention and screening and activities like this are thought of in the domain of the general practice environment. That is probably going to remain, but within that general practice, and I say environment very carefully, an important element of the medical workforce in that, the health workforce, is nursing staff. I think particularly when one starts to think about the way in which things may be done most efficiently, particularly the engagement with communities and individuals in the community, I think there's a very particular role for nurses to play and I will ask Heather to make some more comments.

In the background material that we were presented there was a very interesting model about a flat structure of community nursing care in The Netherlands to show that, with the same output of funds, a decrease in hospitalisation, improved health costs and greater satisfaction among people in the community, and I think that you need to think very carefully about what can be done to augment those nursing systems. Heather?

MS SCOTT: Thank you, Andrew. Just briefly, I have worked in about eight GP clinics across the Latrobe Valley and south Gippsland and all of the clinics work very, very differently. One of the most effective things in the clinic that I have just come from is new patient checks. So, every patient that's new to the general practice sees a practice nurse. The nurses collect very important information: Smoking status, allergies, family history and some baseline readings, height, weight and blood pressure.

I have worked in specialist clinics and I currently coordinate a clinic for children in out-of-home care working with paediatricians. Referrals come through with one line, "Please see this child in your program." There is no mention of allergies, nothing about their immunisation status, not even a height and weight. So, practice nurses can make a real impact on your data in general practice.

The other thing is, too, there's a real lack of experienced general practice nurses in the Latrobe Valley. We have had nurses newly recruited from the hospital. The hospital environment is vastly different from working in general practice and there's a real need for some quality

education for nurses new into GP clinics. There is a lot of information about nurse-led clinics and how successful they are. I worked in a very large GP clinic in Traralgon a number of years ago. That clinic was involved in a national program improving the health of patients with diabetes and heart disease. After 10 years they are still sending in data and they are still one of the lead clinics. That was run solely by nurses, it was very, very successful and other clinics in the area could take their example and utilise the same things.

There's a real under-utilisation of the MBS item numbers in GP clinics as well. Patients between 45 and 49 can be offered a one-off health assessment. The last GP clinic I worked at I sent letters out. Hardly any patients were interested in it. It also depends whether you work in a bulk billing clinic or a private clinic. At the private clinic we had a great uptake by the patients. There were a lot of diseases or risk factors identified in those assessments and they really did work. They are run by nurses. Thank you, Andrew.

PROFESSOR TONKIN: Thanks very much. So, more specific things in terms of possible funding. We believe that there's a role for funding of a community liaison officer because we think, for example, to reach some of the most difficult groups that such a person would be invaluable. To take, for example, Aboriginal people, one cannot go and just knock on the door of an Aboriginal person, even their elder, and say, "We would like to come in and talk about screening." One has to go through a process, which is understandable, of building up the confidence to enable that engagement to occur and equally then with that person

who might be engaged, such as a community elder, to take a leadership role in engaging with the people in that community. There are many other examples of that. So we think that would be a useful thing to do, this liaison with the community groups.

We think that there needs to be a nursing liaison person who might liaise between the hospital, but more particularly with the medical practitioners in the general practice environment. Case managers again could be nurses and again this is integrating with the chronic disease management process but obviously there is the possibility of people being led through this pathway that they get on to if they have early case detection, equally if they are found to be high risk and, as I said, in some cases can be considered to have an early problem, medical problem at that time.

We need to think about funding for screening possibilities in the community, going out to the community, having the champions and the leaders in those population groups enabling that process to occur. So the role of community champions and leaders is important.

Transport. Alistair Wright made the very valid comment that what he would like in terms of enabling of transport is a train station right here. A train station right here would enable the access to the hospital and would enable the access to other things that might be centralised about here. There is the question - I'm sure this has come out - about how you might subsidise costs to get people in for their chronic disease care as well.

But the point that we are making is that this is not something that's just about health. There needs to be

intersectoral engagement beyond health. As I said, transport is one. Employment, if we are going to employ these people, these are employment opportunities in the Valley and that is a very good thing to think about in terms of enhancing the workforce here. The regional office, other things as well, offices of Aboriginal affairs and so on.

I think it was very, very interesting to see all the submissions that have been made by people for our group to look at and relate into this inquiry. When one looks at the offers that came out, from the non-government organisations, from VicHealth, from all those people that were there, I think every one of those should be examined to the extent to which they can be engaged and the offer taken to help out where they can. I will talk about that in a minute because there's a lot of goodwill to try to help the people in the Latrobe Valley.

In the short term, next slide, and I really have to thank John Arkinstall who was in our group and made a very valuable comment and contribution which led us into a discussion. We believe in the short term that we should have a community screening day, that you should have a community screening day. That would be coordinated by the Latrobe Regional Hospital, but it should engage all relevant parties. That includes the community groups, the health professionals, the NGOs, et cetera, et cetera, et cetera.

We believe that such a community screening day would be invaluable for a number of reasons, beyond just the screening, one of which is I think it would be an early give back to the community to show that people are

really concerned about their health and they want to improve their health. They are thinking about the effects of the 45 days of the coalmine fire, but more broadly about the pre-existing and future health of the Latrobe Valley. I think given that the burden of disease, 80 per cent of disease burden is around chronic non-communicable disease and that is growing, I think this screening day would be actually very, very important. I think it would gain trust, it would gain I think some awareness at the community level about health, it could be supported in all manner of ways by the media, et cetera.

So, apart from that, and we think that would be something that we would highly recommend and, depending on the evaluation, it could be something that would occur at a later time as well. We believe at this time the cardiovascular disease, diabetes and mental health screening has sufficient evidence to warrant their introduction at this time and, in the case of CVD and diabetes, Medicare item numbers exist to support that and I think there may be cost effectiveness data to suggest going beyond that.

If you initiate something around the age of 45 or 50, there's a possibility of adding on, with the subsidy of funding needed, other aspects that might be screened at that time and that needs to be thought through. But I think that's a possibility, but it would need augmentation.

It shouldn't just be restricted, though, to people around that age group. We have heard from David about perinatal depression, but also there will be high risk younger people, for example, children of those who

have had a heart attack or stroke at a young age, other very high risk groups in terms of other disease states who should be looked at and screened at an earlier stage as well.

Right at the start one needs to put in place the evaluation processes. One needs to put in place something that is sustainable and is shown to be sustainable on the basis of the evaluation of outcomes and the cost effectiveness. So therefore at this time there needs to be the discussion about data linkage with measures such as hospitalisation and disease specific mortality and I think the opportunities exist to build on what is being done with the Hazelwood health study, but also to go further than that and say we want to do this for the community, if we have the community agreement that this is a good thing to do, and also another major aspect of the evaluation is community satisfaction. Hearing back from the community about what they think is important, what is effective and how that can be improved in the future.

Next slide. In the medium and longer term there needs to be a continuation of screening activities, informed by that ongoing evaluation. There may be possible new projects such as lung cancer screening. One could think about the 15-fold increase in lung cancer in those who have been exposed in the past to asbestos and who are now smoking, and I think the thinking about that starts now and when it is implemented I think would depend on what is found as a result of those evaluations.

There should be measures to overcome the fragmentation at different points in health delivery. But the next thing which I haven't put in here, which I think

is absolutely critical if one is screening, and again to emphasise this, one has to think about what comes next, where is the next part in the medical care system that is going to be impacted, and that gets into the chronic disease management and one has to have in place what are the most effective and cost-effective ways of continuing the ongoing passage of that patient through their lifespan.

Then I think in the longer term equally I like the idea of comments, and I think that is something that really needs to be thought through, but the principles that have been enunciated by Don Campbell and David Clarke, and the fundamental thing there is progressive empowerment of the community in deciding on their priorities and engaging the expertise which they think should be there to help them go forward.

I should ask Alastair and others if they would like to add any other comments before we throw it open.

DR WRIGHT: My only additional comment would be to reinforce what you have said about the fragmentation of services and to improve linkages between community practitioners and hospital practitioners, where I think the role of a GP liaison officer can be very good. Picking up on Heather's point, it is not acceptable to send a patient to a clinic saying, "Please do the needful." That involves education and support of our colleagues for them to better capture the identity and needs of their patients. So I actually think a lot of this begins with better organisation of services, then probably lots of nursing.

MS SHANN: Alistair, can I just ask you to expand a little bit on the idea that the group came up with, which is really

John's idea, about the community screening day. There's a reference to "coordinated by the regional hospital". Could you just expand on what the group thought that might look like, what the barriers that would need to be addressed and planned in advance might look like.

DR WRIGHT: Sure. I think, picking up on Andrew's point that it's a give back to the community and a recognition that they have significant health needs that could be better addressed, I think is a good one. The concern would be that you only preach to the converted, and Paul - I'm sorry, I've forgotten your surname - who is involved with the Loy Yang power station raised the point that they do provide screening for their employees, but a significant percentage and usually those with more health problems don't actually take up the screening.

So I think there's going to need to be some significant resources put into how we go about making sure everybody is aware of that and reaching out through community linkages to the people who aren't as well off. I think if we are able to do that and sell the message, I think that would be a very good thing both for the region and the hospital.

PROFESSOR TONKIN: If I can just add also, and I hope it's okay to say this, Kellie O'Callaghan, who is the Chairman of the board of the hospital, made extremely important contributions to our discussion and she has volunteered to be involved in thinking further about this and taking some leadership role if it is deemed this is a good way to go forward.

PROFESSOR CLARKE: Screening is closely tied with health promotion and there are a lot of reasons why people who

need it don't always use it. Being involved with Beyondblue has taught me that, with persistence, barriers can be broken down. So, it's about persistence about messaging over a period of time gets more people interested in or willing to examine themselves, be tested, seek help when they need it. So, we are advising and encouraging more than one day of screening, but keeping it going.

PROFESSOR TONKIN: And I guess the one thing I should have added is that I think it comes back to one of the earlier slides that I showed. It needs to be carefully thought through for whom and for what, and all those questions that I put up that need to be addressed in thinking about screening need to come into the discussion. But I think appropriate screening would be a very good thing for the community and would get the program off and running.

MS SHANN: Heather, do you have any thoughts about how to do that reaching out into community to be including the particular groups which might have an element of social disadvantage or particular high risk?

MS SCOTT: There is a whole department at Latrobe Community Health who deal with health promotion and they would be able to give you those answers. I have participated previously in health promotion and assessments at places like Farm World, but it needs to be somewhere local. Even health promotion activities in shopping centres are effective. I have done that previously in towns like Moe and we had an enormous number of people go through. You have a captive audience there, a simple record for that person to take back to their GP and many of those patients actually followed up. So I think that they are really

appropriate places.

PROFESSOR TONKIN: Which actually leads on to one thing again that I forgot to mention, which is the importance of information management systems. I'm sure it has come up in many of the fora, but this is absolutely critical.

MS SHANN: Daniel, did you want to add anything to some of these, the short, medium and long term measures which have been recommended by the group, particularly from that background of you said something already about whether or not CT scanning is cost-effective and so on in your particular area.

DR STEINFORT: I guess the particular sort of thing about the medium and longer term, what's still being examined, unlike perhaps some of the cardiovascular end points and the mental health end points where the risk profile is very well established and the benefits of intervening at that point are very well established, certainly the risk profile is clear especially for lung cancer and certainly for chronic smoking related lung disease.

Taking smoking cessation aside, the point at which to intervene, particularly the degree of risk or degree of exposure, is probably still being clarified. I think the main reason for that is, firstly, for lung cancer screening, which is a long-term project, there is the potential to do more harm than good. For example, if you subject people who have never smoked, who are at low risk but not zero, but at low risk of lung cancer, you will find lesions on CT scans and then those people have the anxiety of what does that spot represent and the impact on their health just purely related to that, but also some of those people would be subjected to invasive

biopsy and most of those people will have spots that are completely benign and they would have been better off if they were never identified. So, making sure that the people that we subject to screening are the high risk patients is the most important point.

I think Alistair and I were discussing that's probably something in the short to medium term which is not immediately applicable to everyday health, but certainly learning more about what is the risk profile in this part of the state and there's obviously implications for the population, but also resource implications that we need to understand in terms of, if we are going to draw a line at a certain risk point, frankly speaking, how much money does that mean we are going to need to resource that adequately, so that if we are going to implement something we should be doing it properly. So that's sort of a medium if not longer term project.

MS SHANN: Coming back to the questions for consideration, is that squarely within a promising area requiring some further investigation and testing?

DR STEINFORT: Yes, I think it's a promising area and I'm happy to say that because there is no doubt from international studies that there is a strong role for CT screening of high risk individuals. What is less clear, and again Andrew mentioned this in relation to comparing things with the UK health system, there are certain individual characteristics of the Australian or Victorian health system that means we need to understand more about how to target people and what the cost implications are going to be for that. So I think it's very promising. It should be probably done in the longer term, but exactly how to do

it is something we will be looking at.

MS SHANN: I will throw open to the board. Alistair, did you want to follow up from that?

DR WRIGHT: Only that I think we could make it a reasonably short term goal to understand more about the demographics of the risks of lung cancer. I don't know how many people are at high risk in the Valley and it is certainly pertinent to what we are talking about today, so we will be in touch to get something going.

MS SHANN: Excellent. I love the idea that the working group is going to continue after today. Just before I ask if the board has some follow-up questions, I just wanted to ask really each of you: What are the top priorities here? There's a number which have been listed. If there was really just one or two measures which the board could ultimately recommend or that could ultimately be implemented, where would you land on that? David, did you want to address that question?

PROFESSOR CLARKE: There are two things, I think. One is we are arguing that screening is effective and it should be systematised through the health system in the Valley, so that's a health systems problem and, two, we as a group are recommending strongly that a good idea is to have a screening day or some event like that, for two good reasons. One is it will identify some people who need more treatment or help, but it will also give a clear message and encourage people and start people to think about their health and seeking attention.

PROFESSOR TONKIN: Maybe if I could have two. One would be to think beyond, even though we have talked about screening disease states, to think beyond the individual disease

states and to think about the fundamental determinants of health and disease in a community, and that leads into thinking about vulnerable groups, why they are vulnerable, what might be done, because what is done for those groups is going to cut across everything and it's going to cut across all the other deliberations, I suspect, of the board of inquiry.

The second one, because I saw there's something on chronic disease management, is to think about the fact that many people have subclinical disease. That's about early detection, high risk, et cetera. But to take the opportunity, when someone has a chronic disease manifest, to think that that point where they might have gone into hospital and are discharged is the first step, the early stage to the next presentation with that problem which may be fatal, and therefore to enhance the services that take the patient out of, say, a hospital environment with an acute problem into the community and enhance that, because that is the next phase of ongoing prevention.

If you take the case of coronary disease, five per cent of adults have the hospital discharge diagnosis. They account for 50 per cent of coronary deaths in non-fatal infarcts and about half of them are coming from the people who have the disease. We simply must take proven effective therapies, lifestyle advice to them. That's the low-hanging fruit.

MS SCOTT: I would like to see improved systems in GP practices and the implementation of nurses and promoting of the nurse's role and getting more experienced nurses in the region.

MS SHANN: Alistair?

DR WRIGHT: Train station.

MS SHANN: We will get you to identify where it should be put, rather than Andrew.

DR STEINFORT: My thought would be the most valuable tool will be a system or an approach to access the most disadvantaged group in the community, because I think they are at risk. There are lots of services already available. That's the group that are not accessing them currently and they are also the group that are at highest risk of adverse outcomes in the future. So targeting them I think is going to be where a fantastic amount of gains could be made, with whatever intervention we want to apply.

MS SHANN: Is that partly linking into the idea put forward of community liaison officer?

DR STEINFORT: Yes. We have already covered that, Rosemary has covered that, but GP and particularly community liaison, and I think Kellie had volunteered to advocate and actually deliver the message from within the community rather than outside.

MS SHANN: I will ask the board whether there's any questions for the panel.

MRS ROPER: I have a question back on the community screening day. It's actually outside the remit of your discussion but, Professor Tonkin, you have raised it a few times and it struck me. If we have a community screening day or week or continual, what are your thoughts on what we can put in place for the so what, what happens after that, so that we don't just raise the anxiety in the community that we have a screening, some things are detected and they end up still on a waiting list somewhere. What do we do after

that?

PROFESSOR TONKIN: I think that probably interfaces with the chronic disease management discussions and I don't know what took place there, but I think you can't just have the screening day in isolation. One has to think about precisely what you have said. You can make some estimate of the number of people who you might find, for example, are estimated to be at high absolute risk of having CPD events and you should do something about it in terms of not just lifestyle advice, but drug treatments as they are appropriate.

The estimate, for example, in that area is that if you take all adults between the age of about 35 and 74, that maybe 15 per cent might come out as having an estimated high absolute risk, so you have to start to think about what you do with them. You can make estimates about the number of people you might pick up with diabetes, et cetera.

So, I think that going on from that you need to, one, engage and think about what would happen at the general practice level. One has to think about what would happen at the hospital level. We discussed but didn't talk about the fact that there could be a risk clinic or it could be called a post screening clinic, it could be something that one could fund and have a clinic in the hospital to initially deal with this and it could be done across the disciplines. I don't know whether you want to add to that, Alistair.

DR WRIGHT: Only in as much as I think the GPs would have to be very much brought along at the planning phase, not only to recruit patients for such screening, but also to look

after them afterwards.

PROFESSOR CLARKE: Sometimes people are nervous about screening because it will uncover problems that weren't identified. They are problems that exist. It's just we are going to identify them earlier, so we are bringing forward the treatment. So the burden of treatment, if you like, or treatment services, is no greater; we are just going to do it now instead of waiting for the person to get sicker.

PROFESSOR TONKIN: But one could find, for example, in a newly diagnosed - I don't know what you would call it - clinic and indeed if you are identifying these people and initiating effective treatment, it's going to be cost effective.

DR WRIGHT: If that was nursing, then I don't think it would be confrontational to existing health services.

PROFESSOR CATFORD: Can I follow up and really just focus on this issue of coordination of service response and the aspect of fragmentation. It seems to me that the hospital has to be a player and there's general practice, community health, potentially employers, other people that reach out to the community, community organisations of all kinds. Sporting organisations we heard yesterday were interested in getting more engaged in health related issues. Perhaps you didn't have time, but how could all these players come together, do you think, in a coordinated concerted approach?

PROFESSOR TONKIN: I wonder whether Alistair and Heather would speak about this coming from the community, or we could make comments?

DR WRIGHT: I think you are right. I think when I said this sort of screening day would have to have a lot of

engagement, that's the sort of thing I was thinking about. I was also reflecting on the efforts that prostate cancer movements made. I don't know how many of those guys go and actually get a prostate check, but thousands of people come along to the Big Blokes Barbecue and done right I think it could really engage the community around health and I think it would be a good thing.

PROFESSOR TONKIN: I think there has to be a group that is brought together, given authority and they have to be specifically resourced to actually take this forward and there has to be very careful thought about the governance structure, there has to be very careful engagement of the community and not just the downwards approach, it has to be with, and I think that equally this could be seen as something that, although it might be unique to the Latrobe Valley, there may be interest in seeing how this might work elsewhere because I think everyone is grappling with the problems of what you do with vulnerable communities, including those outside a metropolitan area.

DR WRIGHT: Taking the example of the Big Blokes Barbecue, I don't think anybody pays for their own seat. The table is bought by an organisation or a sporting club or raffled, so that's the sort of engagement that would take place to have people attend.

PROFESSOR CATFORD: We are looking at some other aspects which will touch on this in subsequent forums. We have a special forum on community engagement. We will be looking at healthy workplaces tomorrow. There's a whole piece on governance and leadership and coordination that's coming as well.

Can I say I found this extremely valuable and

very clear about what your thoughts are, which I'm sure we will be looking at very diligently and feeding on to some of those other groups that will follow you. Thank you very much.

MS SHANN: Thank you.

(Short adjournment.)

HEALTH WORKFORCE

MR ROZEN: We will make a start. For the next session we are concentrating on the health workforce in the Latrobe Valley, and particularly in relation to issues that arise concerning recruitment of health workers, doctors, nurses, allied health workers and others, and also retention in the Valley once people are recruited. So we had a very lively and useful discussion earlier today with our group.

As I think is the tradition, we might just introduce the members of the group, perhaps starting with you, Pip, if we could, just because you are on the end of the line there.

MS CAREW: Pip Carew, Assistant Secretary of the Australian Nursing and Midwifery Federation.

PROFESSOR CAMPBELL: Don Campbell. I'm a general physician at Monash Health, and co-author of a submission to the coalmine fire inquiry with David Clarke.

MS SHEARER: Marianne Shearer, CEO of Gippsland PHN, Primary Health Network.

DR FRASER: Simon Fraser, Chief Medical Officer and paediatrician at Latrobe Regional Hospital.

MS CAMERON: Amanda Cameron. I'm the Director of Nursing, Midwifery and Clinical Services at Latrobe Regional Hospital.

MR RAVEN: I'm Dean Raven. I'm the Director of Health

Workforce at the Department of Health and Human Services.

MS WALSH: Katherine Walsh. I lead the policy unit at the Australian Medical Association, Victoria.

MR ROZEN: Thanks very much. As we can see, we have a very wide range of experiences and job roles that are relevant to the topic that we are looking at. I thought it might be useful to start as we did in our discussion this morning, and that is to focus on what the problem is in relation to health workforce. So if we can perhaps define it and get a bit of a sense of where the gaps are, where the problems are, and then we can move on to talk about the ideas the group had for addressing those.

Perhaps if you don't mind, Amanda, if we start with you in your director of nursing role at the hospital, if you could share with the board your experiences in relation to issues around recruiting and retaining firstly nursing staff and then if you are able to also talk about allied health workers as you did this morning.

MS CAMERON: Yes. In the nursing division we are actually quite fortunate in the Latrobe Valley . We have a training provider in Churchill, the Federation Uni, who has a school of nursing, and before that it was Monash University. So the large majority of our student places at Latrobe Regional Hospital for nursing are taken from that university and also our graduates come from that university, so we have had over the years a steady supply.

Nursing at the moment is in a very small window where there is an increased supply to demand across the state and Pip actually spoke about this as well. So, at the moment we are able to recruit to our positions. However, as we know from the health workforce data, that

window of opportunity is very small and we are just about to head into the precipice that everybody else is heading into with an aging workforce.

At Latrobe Regional Hospital we have a very structured program from a nursing point of view, two graduate years, a development year and into postgraduate which is very well supported. So, from a nursing point of view we felt that there was some gaps in relation to our midwifery training from the point of view that the Federation Uni chose to stop a double degree in nursing and midwifery this year which we have used extensively to fill our positions at Latrobe Regional Hospital in our maternity section and because of that course we have actually been able to achieve our full EFT in an area that we struggled to find midwives for before. So that will impact on us greatly.

Also we have mental health training as well. So we felt that there would be a lot of benefit in being able to have mental health training actually delivered within the Latrobe Valley.

From an allied health point of view, we have a lot of difficulty recruiting allied health. There is no allied health undergraduate training in Gippsland. Federation University, who now provides out of Churchill campus, has allied health training but at their Ballarat campus. Most of the undergraduate allied health clinical placements come from Monash University at Peninsula.

We get a lot of first and second year allied health. They come through, they rotate through, they stay for one or two years and then they go back to the city. So we have a lot of junior experience, we have some senior

experience, but we are lacking in the medium or middle experience I suppose is what we talked about. So that's actually quite a large gap.

Social work is very difficult to recruit to and training as well, and we also talked about the fact that one of the areas that is difficult within the hospital setting is from the radiographer stenographer point of view. Stenographers are very difficult to recruit in the country.

MR ROZEN: That's terrific. Perhaps if you can just expand on that last point before I let you off the hook. We talked in the meeting this morning about the implications of the shortage of stenographers and how that flows through to the level of service provision that can be provided. You talked about, for example, delays in people getting ultrasounds.

MS CAMERON: For instance, because there is a shortage of stenographers, so it is difficult to recruit to those in regional areas, we have a limited number that are on call to provide a 24-hour service, so therefore the conditions that we tend to call them out for are limited. So, we have a criteria that we will get a stenographer out of bed for; otherwise then it will wait until the morning. So that has a flow-on effect for the whole flow through the emergency department and how we more effectively treat people, I suppose.

MR ROZEN: Thank you. Simon, perhaps if I can turn to you and get you to address the same question but from the point of view of doctors and specialists.

DR FRASER: Yes. Thanks very much. I guess we started this morning by noting that probably the last few years has

seen, at least as far as Latrobe Regional Hospital and the Valley is concerned, and I'm speaking initially from the perspective of the hospital, that recruitment of senior doctors has become easier. There are still some pockets of areas where recruitment is difficult, and probably the standout is mental health. That probably came across yesterday. To a lesser extent now obstetrics and gynaecology, anaesthetics and emergency department. I think there's probably, we discussed this, probably a number of reasons for that in terms of I guess a wave of international medical graduates coming through for the last 10 or 15 years and moving through the specialty training in addition to those who are Australian trained.

We talked about junior medical staffing and the fact that we have developed a growing Gippsland and rural intern training program and also a rural generalist pathway to support and encourage general practitioners to have further training in anaesthetics and obstetrics.

I think we are probably slowly moving into a new era in terms of not so much struggling with recruitment of senior doctors, but retention, and we spoke very much about what issues might there be in relation to families and children and supports and infrastructure, the importance of ensuring that networks are maintained with tertiary centres in Melbourne, particularly in relation to the ongoing education and training of the senior doctors.

We talked about the need for incentives to attract and retain doctors to the Valley. While it's perhaps not specific to the hospital set-up, there was also discussion about general practitioners and I think it highlighted to me that the net increase in general

practitioners in the Valley in the last 10 to 15 years has been close to zero per cent change, and I think it's a significant area that needs to be looked at.

We feel that the relationship between the hospital and Monash University, at least in relation to medical students, is good and continues to improve. We felt that there's potential to continue to try - and not just with medical staff but with health professionals in general - to try and reach out to the community and particularly high schools and to look at ways of perhaps encouraging local students to consider working in the area of health and how we can encourage and entice that.

I think we also touched on the opportunity to continue to look at funding opportunities to provide incentives and ability to continue specialist training and the relationship that we have with the colleges in terms of training specialists.

MR ROZEN: Thank you. Katherine, from your perspective within the AMA there is obviously a lot of experience about these issues, not necessarily in relation to Latrobe Valley, but broadly in relation to regional Australia. Is there anything you would like to add, please, to that?

MS WALSH: Just that on a broader sense those social issues and social networks around attracting doctors to an area are really one of the key aspects that need to be focused on, opportunities for partners in terms of employment and social engagement, schools, all of those kind of things. It's certainly not unique to this area, but if your husband or wife can't get a job that's similar to what they're doing in Melbourne, they are just going to flat out refuse to move somewhere else because they're giving

up their own life and career.

Also, definitely just what Simon touched on about the connections back to colleagues in metropolitan centres, having those networks there, opportunities for training and making sure that they are not missing out on vocational training places, specialty training pathways, any of that, because they choose to relocate to a rural area, and recognising of course that the easiest way to get people to live, work and everything in rural areas is if they are locally raised and educated as much as possible.

MR ROZEN: Thank you. Don, I think you also had some observations to make about this issue, particularly in relation to doctors and I think it might have been you or someone in the group referred to fly-in, fly-out doctors and the issues that that may give rise to.

PROFESSOR CAMPBELL: Thanks, Peter. I think we are touching on the issue of social capital and it's not all a one-way street. It's very important to have in the region the ability to attract and retain doctors and families. They actually contribute an important component of social capital of the region and if the doctor is only coming in and then going out, then they are not contributing to the social capital, they are not contributing to the infrastructure, to the life of the community, and those are very important points of engagement that flow through to some of the perceptions around engagement and connection and understanding of the local environment.

I think Wendy from Voices of the Valley talked to us about, in training the doctors, they had to be doctors who understood the local environment. At one level that's

a technical task to understand pathways, to understand how to manage individual diseases, but diseases occur in people and people live in communities and it's important for doctors to be part of that community. So that's a very important part of serving the community as a doctor, is understanding the local community and frankly being part of it.

MR ROZEN: Marianne, in relation to pathways, that was something that we did discuss and particularly following on from the question that Wendy asked from the floor in our group, this issue of doctors who might be new coming into the Valley, especially ones who are commuting to come and work here, not necessarily having a thorough understanding of the community in which they are working and particularly the disease, the burden of disease and the particular issues such as the mine fire, for example, and we discussed in the group how that might potentially be addressed perhaps as a short-term response to the inquiry in relation to the pathways. Perhaps if you could expand on that and explain to us what a pathway is.

MS SHEARER: Certainly. To begin with, a care pathway is where a clinical and a medical treatment process might be defined. So if we take the respiratory care, the pathway will identify the assessment steps, the management steps, referral, treatment steps, and that can be documented. So the experience that I have had and that Gippsland PHN are going to be working on as a priority area over the next year is to develop pathways that can be accessible to local GPs and other providers.

The pathways are developed together between specialists in the area and the local GPs. It relies

heavily on champions in the community and that local leadership and once they are defined and this information is placed on a web system, it becomes accessible to so many people. You can not only use it for a clinical definition of what to do, where to find information, where to find resources and that's extremely helpful for new people who are in the area, it's also a one-stop shop for those who are already here and have long been here and they can keep up with the latest trends and the latest research and treatment regime.

The other aspect is that the pathways can have information on what are the latest social and other challenges for the community. So it can identify some of the methods that are used within a particular community, what's common in the community and it can help the providers that are moving into an area to understand "How do I assimilate within this community" from that professional sense. It certainly doesn't replace how to engage and become part of the community, but it gives that first place and one-stop shop, "Where do I find clinical information, where do I find process and referral information and how do I support the people that I care for within that community."

MR ROZEN: Thank you. One of the issues that the group discussed this morning, if we can move to perhaps some answers to the problems that we have identified, one of the issues that was discussed was linkages with hospitals in Melbourne and the ability to draw on or perhaps to share staff and to have staff that are placed in the Latrobe Hospital whilst also having roles in relation to city hospitals.

Simon or Amanda, is that something that you are able to share? You are each pointing at each other. That concerns me.

DR FRASER: That exists already to a degree in that certainly a fairly large proportion of our junior medical staff rotate out from metro, particularly Monash and Eastern Health. One of the things I think we have been talking about today and perhaps there may be some opportunities in the future is to continue to grow Gippsland training in some of the vocational areas. At the moment, as I mentioned earlier, we have the Gippsland rural intern training program, so we have 15 interns next year who will be doing their entire intern training year in Gippsland, either at Latrobe Regional Hospital, Sale or Warragul. There may be some opportunities in the future to perhaps look at that model in perhaps some of the other vocational specialties, for example internal medicine, where you perhaps have junior doctors doing most of their training in Gippsland or in the Valley and then rotating in.

At Latrobe Regional Hospital we have started looking at partnerships with other health services in the region in relation to senior medical staff and I think there's certainly some opportunities to do that moving forward.

MR ROZEN: Amanda, is there anything you wanted to add to that?

MS CAMERON: I think one of the examples that we used was the Maternity Connect program that already exists, and this was used as an example of how people within a rural area can maintain a currency of practice and keep up with best practice without having to move to Melbourne, is that the department has funded a program called Maternity Connect

where midwives from other areas, so they can be midwives in smaller health services in the state, can actually come to - I will use Gippsland - smaller health services in Gippsland can actually come to Latrobe Regional Hospital and do some placements here with higher acuity women, higher risk women, and we also send our midwives to Melbourne to tertiary centres to be exposed to the tertiary centre environment and some of the things they see and to bring that back.

So, rather than having a situation where everyone is in Melbourne and they rotate out, we would like to flip that so that we have everyone doing their - everything is happening here and they rotate back into the metro to get that higher acuity or higher level experience and then come back.

MR ROZEN: Is that something that's relevant to the retention of staff, that those opportunities being available make it more likely that people will stay and see a future for themselves?

MS CAMERON: Yes, we believe so, and that the opportunities from a nursing or midwifery point of view and allied health is that if they are established here they usually obviously already have their families here, they have other commitments here, so for them to move to Melbourne for a year to do a course or for 11 weeks to do a course is very difficult. It's much better that we are able to provide those experiences here with the level of scope of practice that's required to work here and that they only actually rotate into a tertiary centre or the metro for that absolutely higher level sort of experience.

DR FRASER: I think that sort of dovetails with another area we

talked about in terms of it comes back to the issue for health professionals, including doctors, in terms of ongoing training and education, is the enhancement and improvement in tele-health platforms, particularly video health conferencing, to really allow doctors and nurses and allied health to be able to attend educational activities in Melbourne without having to add in the travel. I know, for example, if we have to go to a meeting in Melbourne from Latrobe Regional Hospital, we have to add four hours.

MR ROZEN: We heard quite a bit yesterday and also briefly today about the challenges to patients of having to travel and the possible ways in which tele-health might be able to address those. One of the points that came out of this morning is actually that's also an issue for health professionals as well. Are there opportunities perhaps in the short-term for there to be improvements to those facilities here in the Valley? Are there particular actions which might be able to occur in terms of perhaps training people or improving equipment or funding equipment that you are able to indicate to the board?

DR FRASER: Some of the equipment exists already and is improving, but I think it's to ensure the reliability of that equipment, but also the importance of the coordination of those meetings and to have experts, technical experts on hand to assist when the system goes down. Sometimes some of these training activities may not be during the day. They might be in the evening after hours. I think they are areas that perhaps we could benefit by.

MR ROZEN: Dean, you have been sitting there very patiently,

very quietly. From the Department's point of view, one of the points that you were making this morning was about there being a lot happening in terms of training and so on and where perhaps there needs to be some more focus is on networking and building linkages. Is that something that you could please expand on now?

MR RAVEN: Definitely. Just picking up on Simon's earlier point, the focus of workforce development over the past few years has moved from recruitment to retention and retention is about building social capital and building the strengths of what we already have in the community. So, probably about nine years ago state and Commonwealth governments started increasing numbers of students, so medical student numbers have doubled, medical graduate numbers have doubled, the same with nursing and allied health professionals, and we have supported that with clinical placements.

The rural clinical schools have moved a lot of that training and education out to rural areas, again on the basis that if you are able to select people who have done their secondary schooling in a rural area and provide extended rural placement and rural training, it is more likely that those people will stay in rural areas, but it does depend on having those social networks, professional networks and access to advanced skills training, procedural work, research opportunities if possible.

In a rural area it's quite often about looking at how those functions are dispersed and how to bring them together. It's not like in the metropolitan area where you might just have a bricks and mortar precinct like in North Melbourne, for example, where you have all the

hospitals together and all the research facilities together, but there are ways in which you can actually network all the different organisations to create that economy of scale to make it attractive for people to live here and to stay here.

I think the first step in that in my mind was the development of the rural clinical schools because that attracts educators, trainers and a hub of people who can then build in terms of the early graduate training. So, the Gippsland regional intern training program has been expanding in leaps and bounds because we have been able to increase the educational opportunities and the capacity of services in this region to actually be able to educate and train more medical interns. So, capacity building like that grows. The more you actually get junior doctors in and the more you keep them, the more you can actually grow the capacity to bring in more.

So the next stage of that is to look at further early graduate training opportunities, so GP training obviously is very important. The department is funding a rural generalist program which is designed to give medical graduates and interns a direct line of sight into a career in general practice that also includes procedural work. We hear a lot of feedback from junior doctors that they love the opportunity to do procedural work, not just generalism, so they want a bit of a balance.

So we have designed this rural generalist program to provide advanced procedural skills training in obstetrics, emergency department, surgery and anaesthetics and there's been a really good takeup of that as well, and bringing all those things together we will build the

workforce in the region and then, as I said, network them to be able to actually expand on that.

Once you have done that individually for medical graduates, we can also bring in the nurses and the allied health professionals as well. We have a function in the department of workforce innovation and reform and a focus on looking at inter-professional team learning and developments. So that's where we are trying to move the education and training to take the care and the training outside of just the direct hospital environment more into the community, more to where people actually congregate and in their home as well where they need the care. So it's kind of like a gradual growth of the workforce and then expanding it into new settings.

MR ROZEN: Thank you. Katherine, from an AMA perspective are you able to add to that discussion?

MS WALSH: As I mentioned before, just about the importance of maintaining those networks and that access to ongoing education skills. A lot of younger doctors do feel that moving to a regional rural area can be quite isolating in terms of their professional development. They can feel that it excludes them from being able to enter college training programs and also that they don't get just the general access that you would to improve their advanced skills in a whole range of areas.

Interestingly, where young doctors do rotate out through regional areas they tend to find the experience absolutely fantastic, they say it's great, they really enjoy the dedicated teaching time, they get more patient time, they get more exposure to a whole range of things that they would be fighting with a lot more interns or

young doctors to get in metro hospitals. But it's just that not enough of them are I guess being exposed or rotated through regional areas to get that chance to realise how valuable it is working in a rural or regional area.

MR ROZEN: Pip, I know you have been sitting there very patiently.

MS CAREW: I'm happy.

MR ROZEN: You're happy. I hope I won't make you too unhappy. Are you able to expand on that in relation to the experience of nurses and I was particularly thinking about I think it was you who was talking about the need for support for nursing staff, particularly in the mental health area. If that's something you can convey to the board, please.

MS CAREW: With nursing, at the moment we have a situation where nurses are graduating and not getting positions in graduate positions and that means that they run the risk of being lost to the profession, nurses and midwives, because they don't get that experience that employers like to employ them.

So, one of the problems we have is the deficits of trained nurses, particularly in clinical specialties like mental health and drug and alcohol, and they are often two distinct areas, so we talked about creating the opportunities for better education opportunities, postgraduate education opportunities and also improved opportunities in the undergraduate courses with clinical placements so that the nurses then come out with a level of expertise to then become employed in those areas.

So that was what we were talking about linking up

with not only health services, but with also the tertiary institutions about looking at their curriculum and improving the amount of time that nurses have to engage with those clinical specialties.

We also talked about the opportunity for nurse practitioners and midwives who have an enhanced scope of practice and can fill the gaps with respect to providing services because they are registered in a way that they can provide management and treatment and assessment and prescribing of medication, so they fit very well with, say, a model of a nurse-led clinic.

MR ROZEN: Don, are there opportunities present within the Valley in relation to this medical training area that we have been talking about?

PROFESSOR CAMPBELL: I think there are very big opportunities. One of the issues is that for the emerging group of people with chronic and complex conditions that we spoke about yesterday, the multi-morbidity patients, doctors are going to have to learn to work in teams. It won't just be the team that works in support of the doctor, much as it's a familiar model to me, and I think that one of the things is how do we have generalist physicians, internal medicine physicians, how do we have specialist nurses, how do we build a model of service around the patient and their family to support them in the community, and how do we train our doctors to work in that sort of environment.

It may mean that there are opportunities for new models of employment, that we won't see the same isolated individual practitioner. They may be employees of the health service or they may be employees of an entity that doesn't yet exist, but somewhere between the health

service, primary care and PHNs. There might be an agency that exists to employ doctors and nurses that actually exists in that space. It might involve a community health service as well.

So, there's a lot of emerging opportunities. The one thing we can be sure of is that for things to stay as they are, everything must change. So change is inevitable and it's going to be an evolving feast, if you like. I think one of the things is that we need to be able to attract doctors to come and live and work here. We also need to look as part of the retention process that careers need to be refreshed probably every five years because nothing is going to stay the same.

MR ROZEN: If I can stay with you for a moment, Don. One of the themes that you talked about this morning was these different ways of working different models of providing medical care, and particularly you talked to the group about the Dutch model, the name of which I always get wrong whenever I try to pronounce it, so I will ask you to do that, if you could, please.

PROFESSOR CAMPBELL: This is a model that has particular appeal called Buurtzorg, which I'm reliably informed is a Dutch word meaning "neighbourhood". So it is a neighbourhood nursing model of care and it builds on a cultural model that was very much part of the Dutch culture in which you had a group of nurses who were responsible for nursing care in a geographical area, and the argument here is that we are not so much caught up with distinctions between professional boundaries, be they nurses, allied health, whatever, and that you have a generalist physician, potentially the whole idea is to coach the patient and

family, and the team that is there does not have a hierarchical management process. If necessary, the team has available to them coaches to coach the team to provide the care.

So this is a fairly radical departure from our traditional hierarchical and instruction and inspection model of care, but deeply rewarding and arguably allows you to reduce your investment in managerial classes and much more investment in getting the team on the ground looking after patients. So it's an attractive, testable model and I could see it being something that has appeal to a community that has a strong sense of itself.

MR ROZEN: Thank you. Does anyone else want to add to that discussion?

MS SHEARER: I can pronounce the word, having a Dutch background. But you did well. To add to that that there is so much opportunity with that team environment and working together - if I just stay with the general practice environment for this component - with the nurses and the whole team working together, there's opportunity for the substitution of care, the sharing of care so that from a workforce perspective if the availability of the medical profession is low then working in a whole team environment there's a better coping capacity with the number of people needing to come through and to have that care.

So having the nurse-led clinics and having the practice nurses being supported and trained to be able to do within the practice some of that nurse-led work to be a respiratory nurse, to be a diabetes educator, to do some of that care planning and really to share that, there's

real opportunity there.

Even from a workforce perspective, if there's some employment modelling where some of the nurses could move around, the Dutch model might be something to aspire to down the path, one or two, three years, but there's some ways of doing that right now where you can share a nurse who can go around to some of the different practices and work together to support the community and make the service available where the community is. It will take a bit of training perhaps and support to do that.

MR ROZEN: Does anyone else want to add to that topic? No. All right. What I might do now, before I ask the board if they have any questions, is follow the pattern that we followed in some of the other sessions and perhaps starting with you, Pip, if you were able to identify two particular strategies or actions that you would like to see implemented that would lead to either improved recruitment or retention particularly in your case of nursing staff what you would identify?

MS CAREW: I would probably identify the opportunity to maximise use of nurse and midwife nurse practitioners by filling those gaps when we have a shortfall of medical staff to perform a role that's beyond just referral. So it is about sort of prescribing and assessing patients and managing their treatment. So that's one thing.

The other thing which would be important is engagement with the tertiary institutions in respect to the curriculum. There's a model for enhancing mental health nursing, and that is a mental health major, so that nurses can come out well prepared and work ready to enter into the mental health clinical specialty. Mental health

is a big area where nurses can fill a gap because, having had a comprehensive training, they are then able to fulfil the clinical need of helping with physical co-morbidities that often people who have a mental health illness experience as well as their mental health issues.

MR ROZEN: I know you weren't here, but from the session yesterday about mental health we know that there are some great needs in that area in relation to the Valley. Don.

PROFESSOR CAMPBELL: One we could do in the short term, within the next two years frankly, is to work between Monash and with Simon and Alistair around a regional advanced training program for general physician trainees. That would not require a lot of work.

The second one in the medium term is having, as part of the strategic plan, a plan for medical workforce development. It might be between the different agencies that have got a stake in that one.

The third one, we talked briefly about it, the concept of whatever initiative is not a pilot initiative but it has to be immune from political interference consequent upon a change in government, because chopping and changing because one is in and the other is out really kills confidence in any initiatives. It's a bit cheeky to say that.

MR ROZEN: It's a theme we have heard a lot I think over the journey. Marianne.

MS SHEARER: I would start with clinical placements and working with the local providers to build the capacity to take undergraduates or graduates, vocational training to increase the ability for trainees to come into the area, to have that experience, so working alongside them to

build their capacity to take more learners in that space.

The other is to build champions who can advocate for models of care, changing models of care which helps to train others in how to adopt and keeping up with change. So that could be in the tele-health models that open up the access to the community to care instead of needing to travel. It could be in nurse-led clinics to increase the access to specialised care and to build care pathways so that information can be shared across a greater community of providers, particularly those that are new to the area.

MR ROZEN: Thank you. Simon.

DR FRASER: I think two areas. One relates to incentives for doctors not only to come and work in the Valley but to stay here. A couple of thoughts here relate to issues around accommodation and I think we have heard about social capital. I think it's very important.

Then we also talked earlier about improvements in telecommunications, videoconferencing et cetera; I think ensuring that platforms are more robust and more reliable, but also the coordination of education; I think trying to overcome that tyranny of distance between where we are and what may be available in the tertiary settings.

MR ROZEN: Thank you. Amanda.

MS CAMERON: The group spoke a lot about growing our own and keeping people local. So moving through the continuum from people who have grown up in the Valley, who have gone to school in the Valley, who are actually trained in the Valley and then work in the Valley throughout their different professions, health professions, whether that's in the Latrobe Regional Hospital, the community health setting or the GP practice across that whole area.

I think that's a major priority and I think that's the key to sustainability. It's not always about importing people. It's actually about doing it yourself.

The second priority is that we need to see a commitment to the further development of the Latrobe Regional Hospital as a regional hospital for the people of the Latrobe Valley and the wider Gippsland area, and a commitment for that to continue.

MR ROZEN: I just ask you to expand on that because I think it is important as a medium- to long-term proposal. You made the observation that the way other regional hospitals are funded and are seen - Bendigo, Ballarat were examples - is different to the way that the Latrobe Regional Hospital has historically been treated, if I can put it that way. Can you perhaps expand on that, and particularly by reference to the figures that you were referring to in the meeting we had earlier, if you can remember them.

MS CAMERON: I can remember them. I know how much Bendigo Hospital cost. Latrobe Regional Hospital is about to go through a major redevelopment, which is $73 million, but that's only one part of a master plan to double the whole size of the regional hospital and to bring it up to a level that is commensurate with a Bendigo or a Ballarat. Bendigo has had $680 million poured into it. So I will leave that figure there for you.

So it's important for the people of the Latrobe Valley and the wider Gippsland to have similar access and availability of services as the other regions do. We do have a very high burden of disease in the Latrobe Valley. That existed here before the mine fire. That may or may not be compounded by the mine fire. I'm very passionate

about it, and most of the people here are, that the community actually gets the services that they deserve.

MR ROZEN: Dean, given your role with the state government I'm not sure if this is a fair question for you and if it is not then tell me, but are there particular areas that you think could be addressed?

MR RAVEN: Certainly. In terms of any growth of services, one thing about workforce is that workforce planning has to happen at the same time as service planning happens because otherwise there is a huge disconnect. Any idea about changes to Latrobe Hospital is not a workforce issue in itself, but that's just a general point.

My main point concurs with Amanda's first recommendation, which is really about strengthening and building on the programs that you already have to grow your own workforce in the Valley. Research shows that even urban people who do studies in a rural area and an extended rural placement are three or more times more likely to actually end up practising in the rural areas and they actually overtake people who might be selected from the rural area and trained in the rural area over time. So it's a very important that training and professional development does focus on local opportunities.

Interestingly, the issue about the midwife training is a key illustration of that because when you have local midwife training you don't seem to have any workforce issue. When the training disappears, you suddenly have a workforce issue. So there is a direct relationship there. That would be my biggest recommendation.

There is a lot of work happening in that space across the whole Gippsland region. Certainly, with the growth of health students across the state and across all the different professions, our focus is on trying to make sure that as many of those as possible go into rural areas and other rural areas where the community needs it.

The second recommendation is really to support some of what the other panel members have said about nurses, midwives and allied health practitioners in particular being given opportunities to work to their scope of practice and being treated as pillars of the health sector. Again the research and evidence shows that when people are given opportunities for advanced practice and better career paths they are more likely to stay. So with some focus on that there will be much bigger inroads into nursing, midwifery and allied health retention.

MR ROZEN: Thank you. We actually heard an example yesterday in the podiatry area where a job was restructured in effect and a person given greater responsibility. The evidence the board heard was that was more likely to lead to increased retention of staff by broadening the responsibilities that someone had. Katherine.

MS WALSH: Really just building on what the others have said in terms of recruitment, more local training, whether that's the relocation of some medical school places down to the area - and I do mean relocation, not additional medical school places; I just want to make that very clear - so that you have local training and then local placements.

Then, in terms of retention, really building those links to the specialty training providers, in particular the colleges, to ensure that all those

opportunities that doctors would be able to access in the city are available in the rural and regional areas, and perhaps opening up some of the training opportunities and placements into more of the community sector, in particular alcohol and drug treatment, mental health and also opening back up some of those rotations into general practice that were available under the PGPPP, which was unfortunately dumped by the Commonwealth government but was a really valuable source of exposure for young doctors to general practice and encouraged a lot of them into that field.

MR ROZEN: For the uninitiated, I might just get you to expand on that acronym.

MS WALSH: So PGPPP is postgraduate general practice, pre-vocational training program. It basically was aimed at junior doctors and also interns. It opened it up to that. They got to do usually a 13-week placement in a general practice setting. It was really, really valuable in exposing them to what it was like to work in general practice. They did have billing rights and everything. So they could treat patients and the practices were able to get some income from them.

From our point of view it actually was also really valuable for showing some doctors that perhaps they weren't suited to general practice when maybe they thought they were, so then they would go in a direction that was more suited towards them, which was also a really valuable experience.

MR ROZEN: Thank you. Don, is there something you wanted to add?

PROFESSOR CAMPBELL: Just a comment, Peter, that we drew out in

our discussion which was that there are actually quite a lot of activities going on already which if brought together and promoted, a coordinated conversation, would constitute an entity. We used the word "precinct", but we got caught up in bricks and mortars around the word "precinct". But actually a heck of a lot of activity if brought together and packaged up could be seen to be very attractive; that in combination with something we haven't mentioned in this broader forum which is that the number of doctors in training in Australia is very high.

I think we have the third highest number of medical students per head of population in the world after Cuba and Ireland, and we have three times as many in training as in the United States. So we have a big workforce that's coming. We used the word "tsunami", and someone on the table said, "Do you think the tsunami might even reach the Latrobe Valley?" I think it will, if this were an attractive region, particularly with the PGPPP and conversations between the entities in the region to turn it into a powerhouse - there's a word - for training of doctors and allied health and nurses, we used the words "magnet hospital status", I think, and we even alluded to the Mayo Clinic, which had started with two doctors in rural Minnesota over 100 years ago, and it's not beyond the realm or possibility to have that vision as a potential for the region.

MR ROZEN: On that very optimistic note, I will ask the board if they have any questions on this topic.

PROFESSOR CATFORD: You have covered a huge amount of ground, so thank you very much indeed. I'm just thinking about this window of opportunity in the next two years with this

new build of the hospital, a new cath lab. Is there any innovation possible in terms of medical recruitment or some strategies you can put into place now that can make sure you don't just perpetuate the drive in, drive out model? Were you able to think about that at all?

MS CAMERON: Yes, we have started to think about that. We are not big proponents of the drive in, drive out model. We actually call them Vikings for obvious reasons which I won't go into here.

We developed a model with our oncologists where we entered into a partnership with a tertiary facility. They actually employed the oncologists. They had the capacity. They had the peer colleagues. The person worked within LRH for most of the time, but then rotated back to the tertiary centre for training and peer support and things like that. That model lasted less than a year. That person then became employed by LRH. We have now moved to actually employing four medical oncologists.

So we are very keen to partner with a tertiary health service to start off with around the cardiac services for the Latrobe Valley and the wider Gippsland, and that's very clear in our brief to the tertiary centre that we will transition to a local model. It's very unrealistic to think that we can provide that initially. We don't have the capacity or the knowledge.

The tertiary centres are very happy to partner with us, and then we will transition into a model that will be sustainable and self-sustaining. They will be employed through our service. So that's sort of where we are thinking at the moment. It's a model that worked very well for us with another group of specialists and that's

the model that we are looking at.

DR FRASER: The other area that I mentioned earlier that we have recently done some work in, and it does relate to oncology, is starting to develop partnerships with our subregional hospitals. We do have the need, but we may need to partner with smaller subregional hospitals to put together an attractive package that creates a full-time position. Therefore being innovative in terms of how we might develop those positions is starting to pay dividends.

We have recently recruited an oncologist who is working full time for the Latrobe Regional Hospital but one day a week is going down to West Gippsland Hospital and, in conjunction with the other oncologists, gives us the opportunity to make sure there is leave cover.

PROFESSOR CATFORD: Just one final question. What is stopping you advancing tele-health in the region? It's running successfully in many parts of the world now: patient to GP, GP to specialist, local to specialist, metro. What 's getting in the way?

DR FRASER: It's coordination. We have been involved in a small pilot - dare I use the word - at Latrobe Regional Hospital in looking at paediatric tele-health where the paediatricians are now increasingly tele-healthing into Monash Medical Centre and the Royal Children's Hospital. I think the success of that now is related to creating relationships and having a position that's temporarily funded to help coordinate those appointments.

We are starting to look at tele-healthing out; in other words, basically paediatricians tele-healthing to general practitioners and even possibly to families in

their home. I think the main barrier for that is finding a reliable platform that can be used by GPs and also by families. We talked about a platform earlier, and we are exploring those opportunities.

MRS ROPER: I just have one question regarding grow your own. I listened to the children and youth panel, which we will hear about and I don't want to steal their thunder, but during that panel they discussed young doctors, a young doctors program of how you value and empower young people to encourage them by saying, "Look, you may well be the doctor in this local hospital when you grow up," and then giving them a role and getting them to start to think about it. I suppose my question is to the locals on the panel. Have you given any thought at all to programs to bring some of the young people into the hospital to empower them, that they can aspire to being a doctor or a nurse in the local area?

MR RAVEN: I can just give a general comment. Going back to the PGPPP - Pre-vocational General Practice Placements Program - experience, it was a 13-week placement. Some junior doctors who went into a general practice just sat in a corner for 13 weeks just watching what happened and they got a really bad experience; whereas other junior doctors went into another general practice and were allowed to actually do pre-consults and things, and those people are the ones who decided they wanted to be GPs. It very much comes down to the individual experience a lot of the time and the goodwill that people put in to providing a really positive experience.

We have worked with a range of stakeholders across the state. The Postgraduate Medical Council of

Victoria, as one example, have a junior medical officer forum. So they come up with great ideas themselves about how to make the pre-vocational years more interesting and exciting. We have a junior doctor redesign program that the department has been running out in different hospitals. I don't know if any are down here in the Gippsland region, but that's another way in which junior medical staff can actually identify an improvement and actually get involved in providing a business case to the executive in terms of how to improve a particular issue that they have identified within the service. Things like that that really show junior staff how much they can make a difference and learn as well how to navigate the whole of the hospital are really important.

We are supporting the Gippsland Medical Student Network as well in which medical students in the region partner up with secondary school students who have expressed an interest in health or medicine, and they give them some mentoring about what it's like to study medicine so that they get a better understanding about what that is as a career path.

MR ROZEN: It just remains for me to thank you all very, very much for giving up a day of your time and sharing your expertise with the board. Thank you very much.

(Short adjournment.)

CHILDREN AND YOUTH

MS STANSEN: We might get started. For those of you who don't know me, I'm Justine Stansen. I'm one of the lawyers assisting the Board and I was one of the resource people this morning in the children and youth session. So we might have an introduction from our fabulous panel,

starting with Claire. Where are you from and your name, please.

MS WATTS: Good afternoon. I'm Claire Watts and I'm from Latrobe Community Health Service and I work as a senior health promotion officer.

DR COATES: I'm Cathy Coates, one of the general paediatricians at Latrobe Regional Hospital.

MS KERSLAKE: I'm Kate Kerslake, Acting Manager, Child and Family Services, Local Laws, at Latrobe City Council.

DR McADAM: I'm Dr Cathy McAdam. I'm the head of general paediatrics at Monash Children's Hospital but I also work as a regional paediatrician in the Kimberley.

MS RICHMOND: Sally Richmond, acting Area Director for Inner Gippsland for the Department of Health and Human Services.

MS STANSEN: Thank you. I might start with you, Sally, just to give us a little bit of the background on children and youth issues in the Latrobe Valley in particular.

MS RICHMOND: Thank you. Our group started off by just discussing what we thought were some of the key challenges here in the Latrobe Valley, so I'm just going to run through a few of those briefly.

Firstly, we know that there's already some significant demand pressures on our system, so in areas such as child protection we know that reports have been increasing by 14 per cent over the previous few years. Family violence, we know family violence reports have been increasing to the police by around 80 per cent since 2009/10.

We also know that we have an overrepresentation of Aboriginal children in out-of-home care. We also discussed the referrals coming in to specialists and

support services were often too late. So, some of the paediatricians who were in our group talked about having referrals for children coming in when they were in kinder or when they were in school and generally the view that that was often too late and there was an opportunity for us to be getting earlier referrals.

Finally, we know that children in the Latrobe Valley are often starting behind the eight ball before they actually start school. So there's the AEDI index, is that correct?

DR McADAM: Yes.

MS RICHMOND: And we know from some of that research that children in the Latrobe Valley are often starting school when they are already two domains behind relative to other areas. So, they are just some of the key demographics that are showing what are some of the challenges and so therefore our group then moved on to discuss I suppose quite a strong focus on the early years group because of some of that data.

Our group went on to discuss the range of measures and with a particular focus on early years, and before we continue on further I just want to make a couple of qualifications. Obviously our presentation today is based on the group discussion and the views of many individuals here at the table and I just wanted to be clear that it's not a consensus view because for some of us like me, as a public servant we are only able to comment on government policy. So I just wanted to be clear about that from the outset.

MS STANSEN: If we go to the first slide. Kate, would you like to talk about the first dot point, which is consulting

families about what will work for them.

MS KERSLAKE: Yes. We discussed very early on that it was important to consult with the community to understand what the barriers really are for families and why they may not be accessing the services like maternal and child health, specialist services and that we may not be getting that early intervention then. So we spoke about how we could do that and how we could really get the lived experience from the community.

We discussed that doorknock has been quite successful at Latrobe with the community resilience team. You can go in informally and have a conversation and get real life experience. Also, Sally discussed two bimonthly forums with the Aboriginal community that have been quite successful, getting 60 or 70 people turning up to those. They were just some examples, but we discussed more broadly about getting the community's views and making sure they are part of the solution.

MS STANSEN: Thank you. Moving on to strengthening the information sharing across the systems, which has been touched on in I think almost all sessions to date, about how it is that some of the barriers to and some solutions to accessing child records.

MS KERSLAKE: There are some barriers. We have multiple systems in all different services, so families are having to tell their story a number of times to a number of different services. There was some discussion around ultimately having a system where core data was shared between services, whether that be health services, education and that sort of thing. There's some systems, there's some trials which, Sally, if you want to talk

about further.

MS RICHMOND: Yes. We just briefly discussed some of the recent models that have been operating and trialled throughout Victoria which are essentially trying to make sure we have integrated care coordination and integrated wrap-around supports and one of the examples that we talked about was the Services Connect trial which is operating in outer Gippsland and in other parts of the state where there's a key worker model and that the key worker then helps to bring together the support services that are needed and then wrap that around the client. So that's really to look at for clients who have more complex issues.

MS KERSLAKE: Then from a system perspective we have been looking at something like a patchwork system that the MAV have rolled out across the state that supports that type of model and also has a parent portal, parent app, where parents can access information, the workers' phone numbers, things like that, on their smartphones.

MS STANSEN: You also raised one of the barriers to that which was being resource intensive. Did you think about how that might be overcome using different networks?

MS KERSLAKE: Sorry, I don't recall that.

MS STANSEN: I think it was the fact of maintaining those records and using perhaps maternal child health records, school records and the like. That's okay, we will move on. Sorry to drop you in the deep end.

So the next slide. In terms of accessing services, Cathy Coates - we have two Cathys on our panel today - Cathy Coates was going to discuss a little bit about accessing services.

DR COATES: I think it's been a common theme. We have heard about it throughout the afternoon about access and that it needs to be community based and that often a big barrier to families is the need to travel, whether that be to Latrobe Regional Hospital or whether it be going to Melbourne.

As Sally has talked about already, we know that this is an area where there are high levels of socioeconomic disadvantage and trying to capture vulnerable families and vulnerable children before the damage is too great or is great, and the earlier in life that we can do that, the better, and without wanting to re-invent the wheel because re-inventing the wheel takes time and there are actually already a number of services in place in the community and trying to link those together in a more cohesive way and that the community values.

We know that the enhanced maternal and child health program, which is a program where instead of the traditional model where families take their infant to the centre, the enhanced maternal and child health service provides a home-based visiting service for families that do have additional needs. We know that's a highly valued service where the nurses are able to visit frequently and that often a fairly close relationship is formed between the maternal and child health nurse and the family, and again we have heard that nurses are often in a really powerful position to then link in additional services.

We know sort of the first four to six months of life is when we really have close involvement of maternal and child health nurses and after that there is a very

steep drop-off and even more so in Latrobe Valley with it dropping down to about 82 per cent by about four months. So, we want to try to use the enhanced maternal and child health service in a way where we have trust from the community, but knowing that the enhanced service can't stay in play for a long time and potentially linking that with an agency such as Child FIRST which then has the ability to provide long-term assistance for a family.

I think linking in with that is trying to better utilise other aspects such as school nurses. We know that the community does use general practitioners and that is a service that they value, but trying to minimise the need for families to travel. So, if we can co-locate services so that they can go to their GP and at the same time fortunately the maternal and child nurse is available so that the maternal and child nurse provides a different service which is extremely valuable to the family. Even though they may have originally gone to see the GP, we can go "But we need to do something more than just see the GP."

MS STANSEN: Thanks, Cathy. Claire, did you want to expand on the school nurse aspect of that particular issue?

MS WATTS: Yes, for sure. Cathy highlighted in our discussion that the paediatricians receive a lot of referrals that are coming in I guess a bit too late, once the children have started attending school, and there's a lot of different I guess screening tests that need to be done when they do come and see the paediatrician and there is obviously a wait list for that as well.

I guess there was a little bit of discussion around would it be a way to help this situation, help the

screening, by better utilising the school nurses in the area and it may be that they can be trained up in some of the testing. Obviously there is a skill set that is needed for some of that testing, so maybe skilling them up to do some of that testing and then making that further referral if need be and just cutting down on that wait list time and keeping the families engaged. That was about all.

MS STANSEN: Sally, did you want to talk about the Child FIRST program about normalising that support level?

MS RICHMOND: Yes. Just in addition to the maternal and child health and the school nursing program, we discussed the need to have really good links into early intervention and family support services. So in particular the Child FIRST platform which is one of the most significant platforms we have in Victoria for early intervention and family support, so the need for that to be well linked into maternal and child health.

Just in the recent state budget the Victorian government committed some additional funding of $257 million to strengthen the support systems for children and families and that did include some additional funding which is rolling out now for early intervention and family support services in Child FIRST here in the Latrobe Valley, so that will certainly be a significant help and is being implemented now.

Importantly, on top of this the government has also recently announced the long-term reform of the child and family services system, and that's called "The Roadmap for Reform: Strong Families, Safe Children" is the name of that initiative, and that will include a form of child

protection, out-of-home care and early intervention services. So, this reform agenda by the government will set out a course of action to improve the service systems so that we can keep families together more during the crises and we can provide early intervention and prevent of course abuse and neglect and, where children do need to go into out-of-home care, to make sure they have the best possible chances in life.

That commitment by the Victorian government we think provides a great opportunity for us to reshape the service system and particularly around early intervention here in the Latrobe Valley.

MS STANSEN: We might move on to the next slide, and between Kate and Sally talk about the children and youth area partnership.

MS RICHMOND: This priority was to continue to build on the work of the children and youth area partnership because we believe it's a very promising new model that we have operating here in the Latrobe Valley. I will just talk briefly about what the children and youth area partnership does.

As we know, responsibility for improving outcomes for children and young people is actually shared by many people. It's not just government; it's also local government, it's schools, it's police and it's community support agencies and of course the wider community. So this partnership is actually quite ground breaking in bringing all the players together, police, schools, community agencies and levels of government, to actually look at how we might drive collaboration more systemically right across the service system and across sectors, for us

to drive more sustained improvements in outcomes for children and families.

So, this partnership has all the players around the table and it's really, I think, driven by some of the research, particularly that came out of Stanford University about collective impact, about how we can use our combined resources because, as we know, there's a lot of resources already in services for young people and children and there is a question about how we can use our collective resources much more effectively.

So this partnership, all the partners come together, we have been looking at the data, looking at the evidence, looking at research and feedback directly from young people themselves and from that we have developed a common set of goals, a common set of priorities and agreed actions that we are then rolling out.

So, the partnership so far has two priorities. Its primary focus at the moment has been on children in out-of-home care, and we have set up four taskforces to drive some improvements for children in out-of-home care and it's second priority work is on early intervention and that's work we are just getting started on. So we think the children and youth area partnership is a really unique model that really is about driving collaboration at a much more system wide level and we think it's a very promising model.

Kate is on the children and youth area partnership. Do you want to talk a little bit to your experience of the partnership?

MS KERSLAKE: Yes, I guess it's place based approach as well. So, whilst there is children and youth area partnerships

across the state, the partnership here focuses in Gippsland. So, the results from the initial priority area for improving outcomes for children in out-of-home care, the activities that are happening in the projects that are happening now, we have had the voice of carers, we have had the voice of young people in the room and they have helped design the projects to get improved outcomes for the children. We think that can be used as a platform for some improvements here and it's got a good governance structure and is represented across a number of departments and agencies.

MS STANSEN: Thank you. We are going to move to the next slide. Picking up a theme that's been developed in other sessions is having people in the Valley who are delivering medical or health services understand the particular health needs of this particular Valley. So, Cathy McAdam, can you please talk to the first bullet point about developing the manual?

DR McADAM: Yes, I guess it relates to the workforce team where, if you have people coming to the area, they need to be orientated to what illnesses and issues might be prevalent in this community, and in particular there is a lot of concern since the fire around respiratory conditions, around any carcinogens or exposures to potential toxins and the anxiety that has arisen from being involved in such a difficult time, and that anxiety can be both in parents and in children.

So, making sure that people coming to the area and working in this area are aware of those issues and any particular things that they need to look at and the corollary was I suppose something that has been done by

the public health unit where I work in the Kimberley where there are red flags so that the excellent junior doctor going up there and seeing the child with a fever and a sore leg thinks rheumatic fever instead of viral illness. So, they are tailored to the appropriate treatment and appropriate investigations.

MS STANSEN: Thank you. Cathy Coates, taking further the children and youth area partnerships and the pathways to good health, following on the current program that's going on here, we had a discussion about expanding that. So I wouldn't mind if you would first identify what the current program is and who it relates to and then also identify where the expansion might be.

DR COATES: Sure. Heather touched on this this morning, the excellent program that she's involved in running which has been fairly recently established called "The pathways to good health" and is focused on providing an initial assessment for children that are in out-of-home care. That initial assessment consists of speech pathology, psychology and a paediatric assessment located all within the one centre over the course of an afternoon, with additional referrals being able to be arranged as seen necessary such as a dentist.

It doesn't provide ongoing care for children, but it does at least provide a snapshot of where that child is at the current point in time and what their needs are, and then directing them towards ongoing care within the community. So that's an excellent service. We thought one of the other areas that is common within this community is exposure to trauma, whether that be exposure to violence within the family home, whether it be exposure

to mental illness of parents or siblings, and that that has a significant impact on child development, and using that model that's already in place and is working well of where a child can be seen in an easy location, accessible to public transport and they can see a number of health professionals within the one setting.

Some of the assessments would only need to be a one-off assessment such as a cognitive assessment. That only needs to be done once, but it provides vital information on a child's functioning and what supports they may need both at home and at school. Certainly if a child is waiting six months to see a paediatrician and then another few months to get a cognitive assessment done at the school before it is actually identified that the child has an intellectual disability, in addition to their trauma background, that's a year that's been lost for that child and that's a lot in early childhood development; so recognising that these kids have additional needs and trying to assess their co-morbidities and then referring them on to the appropriate ongoing follow-up in the domains that they require.

MS STANSEN: Thank you. Moving on to workforce issues which I guess flow from setting up new clinics and new practices, Cathy McAdam, I wondered whether you wouldn't mind talking about the workforce issues for consideration.

DR McADAM: Yes. As well as having a team to actually do the screening and identify the issues and then plan the treatment, then the treatment actually needs to be carried out. Some of that may actually involve specialists who do not work in the Latrobe region. So we need to actually enable families to be able to access those services,

whether that be by enhancing the videoconferencing and tele-health or whether that be reducing the travel by having the train station here and somebody to pick them up at the other end to get to the hospital. I would like a monorail actually to take them from the station into the Monash Children's new facility so that we can actually create the tertiary back-up that is necessary for the Valley because, as some of you may know, Monash Children's Hospital is currently being built to actually open as a separate entity in Clayton in 2017 and we will be the tertiary or we are the tertiary referral centre for this region, so we want to actually enhance the services that we can provide, but recognising that not all the families here have access to a car, that to travel down there takes an extensive amount of time, so if we can actually coordinate appointments so we can reduce some of the costs that are actually involved in families accessing these services and reduce some of those barriers.

So that is something that we felt was important, as well as being able to ensure that the workforce actually working in the Valley are using their time to work smarter not harder, so that if there is a long waiting list for paediatricians that doesn't necessarily mean you need more paediatricians; it actually means that you need to have the services work in a more intelligent way to make sure that the paediatricians are doing the high-end work that they need to do and not doing some of the other things that people are waiting for. So screening and some of the other things can be done by other services within the area: maternal and child health nurses, school nurses and others.

MS STANSEN: We also touched on nurse practitioners and their role in the Valley. Does anyone want to pick up that point?

DR McADAM: I suppose I was just pointing out my experience in Broome again with nurse practitioners is that they are a key element to the health workforce because they tend to be working in the area for a longer period of time. So in junior doctor training you have new rotations every three months. So the level of expertise drops, and then they are just coming up to competence and then drop again. There is always going to be a steep learning curve for anybody coming to a new area.

So nurse practitioners have an extended role or are able to do some prescribing, some other procedures and that might be a niche part of the workforce that we could actually promote. It would also provide some career development for nurses as well, because it seems that you go into admin or into education, but it's actually an enhanced role that might actually be something that people in the area could be proud of.

MS STANSEN: Moving on to the next slide. After our discussion about a lot of the early prevention strategies we also talked about the tertiary end of care. Cathy Coates, would you mind just talking through some of the matters that you raised about the acute services provided.

DR COATES: Sure. Some of the discussions that we had today were about some of the community experiences that they have in terms of contact with Latrobe Regional Hospital from a paediatric perspective. At the current point in time it's a mixed emergency department and a mixed waiting room. As we have heard about, there's a lot of substance

abuse and that leads to erratic behaviour from the adult community. Children find that extremely distressing, to be exposed to high levels of aggressive behaviour within the emergency department. We know that there are a large number of children that leave the waiting room of the emergency department without being seen. We don't have data on why they have left, but certainly anecdotally many families will report that, combined with a long wait, it's also that they don't want their children being exposed to the types of behaviours that are in the waiting room.

As we have heard about today, the hospital is currently undergoing major redevelopment, which includes the emergency department, and we are hoping that some of those issues will be greatly improved as a result of that; ideally to be able to separate children from the adult population both in the waiting area, triage and the treatment area.

Linked in with the emergency department we wondered whether there might be the possibility of being able to set up a service predominantly running in the evening where the hospital is often at its busiest where children with minor illnesses and injuries could be seen not actually within the emergency department but via a GP-led clinic with GPs and nurses that have extensive paediatric experience, and that that would hopefully alleviate the pressure on the emergency department and also be a much more pleasurable and a quicker experience for families.

As we have heard about in the previous session, a sustainable paediatric workforce, as the Valley becomes busier and busier that leads to additional work in all

areas. We want to be able to build a really sustainable paediatric workforce right from the ground roots up, so from the first contact that families have within the emergency department they are seeing doctors and nurses that have paediatric training right through their admission, if it is required; so junior medical staff, including residents and registrar support, right up to advanced trainees and consultant level.

Within the area - so West Gippsland, the Warragul Hospital, and here - there's around about 2,000 births a year and we have currently 10 special care nursery beds between the two centres, which is certainly below what many similar sized regional areas have. Some of that is definitely due to physical barriers which need addressing. But we know this impacts dramatically on families that are forced to reside for long periods of time away from their supports while the infant is in a tertiary centre in Melbourne, and families being forced to make a difficult decision do they stay with their infant or do they stay in their own home with their other children. Trying to combine the two, as we have heard, is extremely difficult. It is a four-hour return trip. We don't like having babies that we know we can manage locally stuck in a tertiary centre in Melbourne because we know we could have those babies back here and back with their families.

MS STANSEN: Thanks, Cathy. Moving on to the next slide, talking about longer term change, Claire, would you like to talk a little bit about programs like Healthy Together and their assessment, their impact on children and its future.

MS WATTS: Sure. I guess I wanted to highlight the fact that

we are all talking about trying to look at some long-term changes and what that actually requires is sustained funding, not just relying on the political cycle of someone pledging money and then pulling it out because of change of government and that kind of thing. If we are going to be able to see long-term changes in the Latrobe community we need to be able to obtain long-term funding that will enable all health professionals to be able to screen, monitor and evaluate what we have been doing and not rush us through that process by knowing that we have only got three years to try and achieve some type of outcome; so wanting to highlight that and get a little bit of support from the government and wider, and understanding that that's something that we are needing to look at.

We have been talking a lot about the medical model of stuff today, but also looking at that social model of health stuff as well and the needs of addressing the social determinants, and that takes time to be able to address those issues, to identify them and address them, and then monitor them and see the improved outcomes of that. So that's what I was touching on with that one.

MS STANSEN: That leads into the second bullet point up there on the screen which talks about some of the social determinants including education. So if you wouldn't mind discussing a little bit about the education, some of the other social determinants and some of the other programs that might assist in improving the health outcomes before they get to the level that they need tertiary care.

MS WATTS: Yes. We have been discussing at paediatric level and the first five, 10 years of a child's life as to how

we can benefit them and their health and address the social determinants and the needs, but also when you get to primary school, secondary school and even tertiary level it's about enabling the students themselves to be educated in this stuff and how they can make those choices for themselves, to make improvements for their health for the long term.

So at the moment some of the secondary schools are working together with the Smith Family and there's that social support that they are getting. The students are coming to school and they have various issues obviously, but there's that support being provided to them through the Smith Family, through the Koori support workers, those type of things.

Also what I work on is the achievement program in the primary schools and the secondary schools. So it's looking at policies, the issues that students have, looking at benchmarks that they can achieve around healthy eating, physical activity, safe environments, so looking at that family violence stuff, but educating the students, the families and the school community on health effects, health behaviours and how we can go about changing those for the better and enabling those students and the teachers to make those choices for themselves to go and speak to the canteen lady about, "That's really not the healthiest food for us. What can we do about that," and not just sitting back and accepting that that's what they are going to get fed but working together with the school community on making changes that will affect their health.

MS STANSEN: One of the examples you gave about that was the committee that was through the school where the student is

a member of. Can you just talk a little bit about that?

MS WATTS: Yes. Part of the achievement program is about setting up a health and wellbeing committee within the school and from there that's where they identify what health issues are going on at that school and how can they go about setting to achieve those benchmarks and getting things right on track.

So one of the schools that we work with quite intensively has put the offer out to all of the students and the parents to become part of the health and wellbeing team. There's a couple of students that are on the team. They speak up. They feel empowered to make a change for their school, for themselves. One example was the school disco. Normally they just offer soft drink and chips. But this one boy said, "We get really thirsty and we don't want to drink soft drink and chips. Can we have water and fruit?"

Because he spoke up and spoke to some of his other friends as well the school then went, "That kind of makes sense," and that's flowed on to the student and his friends and the wider school community speaking up on other issues that they feel that they do now have the power to speak about. That's just one small example of the kids feeling comfortable. It is a safe environment for them to speak up and say what's an issue for them at the time. They feel comfortable and they know that they are going to be listened to, and that's a huge thing for kids, especially in this area as well.

MS STANSEN: That's great. Leading on from that we have our next slide about empowering students. Cathy McAdam, you gave a great example in our discussion this morning.

Would you mind speaking about that?

DR McADAM: As I tried to catch up on my journal reading the other night I was struck by an article that talked about Malpa. That's a program that's in New South Wales where there's actually a retired Aboriginal leader who works in the community with children and identifies these three and four-year-olds as potential future health practitioners and they become the doctors. They come along and they go to their doctor training. It actually improves their attendance. It gets to 100 per cent; in fact probably about 150 or 300 per cent because I think there were 15 children chosen and 45 turned up each time, but nobody was turned away.

These children were taught about health and actually about how to do different things. So they were doing dressings or whatever it might be. They were taught about the actual healing properties and things.

What that then does is those parents say, "My child has been chosen as somebody who has potential." The child believes themselves that the family believe in the education and they actually grow up thinking that there is something more than being on the dole or whatever is the example that they may have had in the past.

Malpa's slogan I thought was quite useful to dwell on. "If it takes a village to raise a child, then it takes children to heal a community". That's perhaps one of the things we have been talking about today, the importance of early intervention, that if we can identify families at the time when they are teachable, when they have a newborn child or during the pregnancy and helping them to identify the potential in their infant and raise

them in a healthy environment, that that actually helps the whole family. It helps their mental health. It helps their physical health. The child takes the message home or to their local school about, "This is what healthy living is about."

It is vitally important that we actually work on the early years in children. Not everybody is going to be a health professional. Other examples of this have been sports academies. In Doveton there's a sports academy that again has helped to engage teenagers and young adults in school attendance and feeling like there is a worthwhile reason for attending school, but also that, "I need to look after my body so that I can actually achieve."

So we see that as very important, to ensure that programs identify and give people hope and take the message back to their own families and community. That may then work into the longer term workforce planning and things. So I wouldn't wait until they are in medical school. I would start when they are three years old.

When you do your community screening day I would have the three-year-olds doing the blood pressures, I would have the eight-year-olds doing the fingerprick glucose because they will do it properly every time, whereas you will have other people taking shortcuts. So get them in early and get the young kids doing it. They will have fun and that way you will get the parents along. So there's my two pennies' worth.

DR COATES: I'm not entirely sure that works completely, Cathy. I'm not the world's best plasterer and yet my father, who is a retired orthopaedic surgeon, had me for years dipping

bits of plaster in a bucket of water as he would diligently apply it.

MS STANSEN: But you did end up being a health practitioner.

DR COATES: Yes, but not a plasterer.

MS STANSEN: I think that leads to our final point, which is really about the fact that all of the aims today, whilst they could be implemented short term, are really long-term objectives because children need time to have that outcome measured. I wanted to throw it open to you all for one last comment or something that is particularly important to you that we have discussed today or that we haven't had a chance to raise. I will start with you, Claire.

MS WATTS: Not so much something that we haven't had to raise but I think that in the other sessions, at the end of the session we have been asking for recommendations and that kind of thing. One point that I made is again banging on about the school nurses, but I think they are under-utilised. I know that there used to be a lot more support for the school nurses in the past, and obviously the monetary commitment to that has gone elsewhere. But I feel if you put the time and the effort and the money into school nurses and being able to address some of these issues that are coming up I think that the benefits would be seen in the long term. There won't be as many health issues and other issues going on if they are addressed earlier.

So that's probably my thing that I want to bang on about, is school nurses and the support for them in the primary schools and also in the secondary schools, because there's a whole other world of things going on in secondary schools that kids shouldn't have to be dealing

with on their own. So that's my two bobs' worth.

DR COATES: For myself, today was a very rewarding experience in being able to interact with a number of other professionals who are delivering services and for me to reflect on that we have a lot of services available within the Valley and I think trying to link them together in a more cohesive, family focused way with some additional sort of work and funding to go into it, we can actually expand on the services that are already in play that already have good models of care and to try and provide a much more family focused service that is going to provide lifelong benefits for children and families.

MS KERSLAKE: I love Cathy's idea of three-year-olds doing blood pressure. For me, it is listening to our community, talking to our community and empowering them to be part of the change. I think that's really important. I think any solution needs to be place based and we really need to listen to the people.

DR McADAM: "If it takes a village to raise a child, then it takes children to heal a community." Get them involved in that community screening day.

MS RICHMOND: We touched on earlier just about the Aboriginal children who are overrepresented in out-of-home care, and I just wanted to come back to that point because obviously we know there are significant Aboriginal communities here in the Latrobe Valley. So I just wanted to make the point that here in the Latrobe Valley we have had the Taskforce 1000 process which has been led by the Commissioner for Aboriginal Children and Young People where they conducted a review of all the children who were in out-of-home care who were Aboriginal to look at what some of the underlying

issues were and the reasons for them coming into care. So that occurred about six months ago.

From that work we have then been looking at what are some of the key actions we need to put in place across both the department as well as other settings and look at how we integrate that with support services and mainstream services so that we can make sure that we have appropriate supports and better supports in place for Aboriginal families both at the at risk end and also when they come into care, how we can ensure that Aboriginal children are connected with their culture. So I just wanted to flag that as an important issue in any consideration of children and young people.

MS STANSEN: Thank you. I open it up to the board.

PROFESSOR CATFORD: Thank you very much. You have covered a fantastic amount of ground and material, and it is hard to sort of think through if there are any gaps. But there is one I wouldn't mind you commenting a bit about. We have heard quite a lot about the importance of joining up the services and the hospital reaching into the community health, into general practice. Can you comment on general practice? To what extent could that service be strengthened in terms of child friendly attitudes and skills and abilities? I'm particularly thinking of Cathy and others who are working actually here in the Valley. How is general practice travelling and are there things that could be done through the primary health care network that could strengthen the service delivery?

DR COATES: It's a good question and an important point. This doesn't just apply to the Latrobe Valley but within any area there are various general practitioners that have an

intense interest in paediatrics and there are general practitioners that really is not their interest at all and they are scared of children and don't want to see them.

Identifying the general practitioners that do have an interest in paediatrics, being able to provide them with some additional education which would be easy to achieve locally, we already have a very robust education for our hospital junior medical staff and I think being able to expand that would be quite easy, in addition to other programs that are available such as the Diploma of Child Health. So I think it is useful for GP practices to identify the one or two general practitioners within their practice that have an interest in child health and keeping their skills up, so directing where possible children to those general practitioners for their day-to-day care so that the GPs develop increasing skills and confidence with assessment of children, what needs referral, what doesn't, the urgency of a referral. As we have heard about again, sometimes it's very difficult for us to assess the urgency of a referral from the very limited information that's available.

So I think that combined with the knowledge that we need to be able to provide an after hours service. A lot of paediatrics happens after hours. It doesn't happen between 9 to 5. It happens after the end of a school day and in the evening. So making sure that there is access to GPs that have skills and are prepared to work at that time of the day, which is not a very family friendly time of the day. So that in itself is a challenge and a barrier, but I think can be worked around with enough interest.

DR McADAM: Could I add something there. One of the things that we talked about was co-location of services and the mentoring and sharing of others who work in that area and feel comfortable. So in Pakenham the Henry Road Family Centre has a maternal and child health nurse working alongside the kindergarten programs, the early childhood developmental programs and things and I have a paediatrician and a paediatric trainee there, but I want to get a GP in there because the GP partnerships in that to actually upskill and develop the relationships with their local services then means you have somebody at the end of the phone. There is lots and lots of information on websites and things, but as a busy GP you don't have time to access those websites all the time.

There are a lot of things that the Paediatric Clinical Network has put together to help people with appropriate referral resources, what to do before referring or in the interim while the child is waiting to see a paediatrician. So there are lots of resources there.

But I think it's the partnership and the person that you know at the other end. So mentoring sort of programs; senior GPs who have a lot more experience in managing that saying, "Yes, you can manage that. You don't need to succumb to the pressure to refer every time. It is actually okay to manage that, but when it gets to this point that's where you need to refer." That's where frequent case reviews with the local paediatricians and GP network education days that are a bit more interactive rather than just a lecture on this or a lecture on that are probably ways forward there.

PROFESSOR CATFORD: Just finally, are you seeing sick kids a bit too late? Is there a delay in giving access to children? Does this raise issues around levels of understanding, education in the community about the early signs of illnesses?

DR COATES: Sure. I think we do see some illnesses too late and sometimes it's a lack of recognition on behalf of the family and sometimes it's a lack of recognition on behalf of the first medical person that they have had contact with. As a result of that, we have instituted guidelines where if a child re-presents within a two-week period with the same illness then they need to be discussed or reviewed by the paediatric team because we know that's a marker, two or three presentations within a couple of weeks is a marker that there's a major problem.

Similarly, we also know unfortunately that children with abusive head trauma, 80 per cent have had contact with a doctor in the previous month before presenting with an abusive head trauma. That may have been to do with a crying baby or reflux or something. But they have had contact. So I think we do see some major illnesses too late.

Having said that, when children do present late or unwell we do have some highly skilled personnel and nursing staff within the emergency department that really do swing in pretty quickly to assessing and treating children. So I think, to me, acute illness when it's severe, we don't see a lot of really late presentations. What we tend to see is perhaps an under-recognition of the severity of the symptoms either by the family or the first doctor that they have presented to.

Certainly in terms of the more chronic disease that's where there's a real issue in terms of families not recognising at all that their child has a major speech delay, that they have a hearing impairment, those sort of things that can easily slip under the radar until four years has gone past and the child goes to kindergarten and it is discovered they can't hear.

PROFESSOR CATFORD: Thank you very much.

MS STANSEN: Before I turn it over to you, Bernie, I would just like to thank you all very much for your participation today. It was a very valuable discussion. As a mother of a three and five year old, it was alarming and enlightening all at the same time. Thank you all very much.

CHAIRMAN: Please stay where you are for another one or two minutes because I also want to thank you. I thank you in the sense of thanking those others who have been on the panel because it is clear that the discussions, the ideas, the suggestions for recommendation that have come now from six sessions have been extremely valuable. We are almost at the halfway mark. So there's a massive amount of material that is going to have to be assessed in the light of what other information we have received from various other sources. So I do thank you.

I thank those who have participated and those who have prepared the way, and that particularly includes John, for what have been such valuable sessions. We will have another three panels tomorrow and, in a sense, one can't help but look forward to being further enlightened. But, seeing you are in front of me, I thank you on behalf of the board and everyone else who has participated.

Thank you all and good afternoon.

FORUMS ADJOURNED